Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Case Ref: **11367656**

1 August 2024

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: North East and North Cumbria Integrated Care Board

1 **CORONER**

I am Robert Cohen, HM Assistant Coroner for Cumbria

2 **CORONER'S LEGAL POWERS**

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 **INVESTIGATION and INQUEST**

On 6 March 2024 I commenced an investigation into the death of Stephen LINDSAY. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Death by suicide.

1a Hanging

1b

1c

II

4 **CIRCUMSTANCES OF THE DEATH**

Mr Lindsay was 71 years old. He lived in Cockermouth, Cumbria. In October 2023 Mr Lindsay was diagnosed with metastatic Oesophageal Cancer. He experienced a number of complications associated with his diagnosis and was in pain.

In November 2023 Mr Lindsay reported to his GP that he felt overwhelmed. In January 2024 Mr Lindsay had a procedure at the Royal Victoria Infirmary, Newcastle. The RVI

Mental Health Team (operated under the aegis of Cumbria, Northumbria, Tyne and Wear NHS Foundation Trust ('CNTW')) subsequently wrote to Mr Lindsay's GP noting concerns about his mental health and suicidal ideation and noting that the efficacy of antidepressant medication should be "monitored by services supporting Steven locally".

Mr Lindsay's GP referred him to the local Community Treatment Team run by CNTW. On 21st February 2021 that team responded: "This is a very sad situation and must be very difficult for Stephen. I am sorry that CTT are not a service that can offer the interventions that are needed at this stage. I am surprised that palliative care/McMillan team don't have staff that can help Stephen understand the diagnosis and prognosis. I am sorry that I can't be anymore help".

Mr Lindsay died on 28th February 2024. I concluded that his death was suicide.

<u>CORONER'S CONCERNS</u>

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

5 (1) I am concerned that providing treatment for Mr Lindsay's mental health was passed between several teams, with none of them being willing to accept that it fell within the ambit of services they had been commissioned to provide. I am concerned that there is a risk that in future cases mental health support will not be provided to those suffering from terminal illness and that this may lead to other patients experiencing crisis and attempting to end their lives. I consider that the lack of clarity as to the responsibility for providing such care may cause further deaths.

(2)

(3)

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you North East and North Cumbria Integrated Care Board have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 26th September 2024. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

8 I have sent a copy of my report to the Chief Coroner and to CNTW.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

1 August 2024

9

Signature

Robert Cohen HM Assistant Coroner for